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**WRITE-OFFS, DECREASES, AND TERMINATION OF MEDICAL CARE
COLLECTIONS FUND ACCOUNTS THIRD-PARTY RECEIVABLE BALANCES**

1. PURPOSE. This Veterans Health Administration (VHA) Handbook defines the procedures involving decreases in and termination of Medical Care Collections Fund (MCCF) accounts receivable balances at all facilities.

2. SUMMARY OF CONTENTS /MAJOR CHANGES. This is a new VHA Handbook, which outlines the administration and responsibilities for identified staff regarding their role in ensuring that all VHA financial transactions conform to accepted government accounting principles in order to eliminate any conflict with existing statutes and policy guidance. This Handbook stipulates the requirement of prior approval by the Department of Veterans Affairs (VA) Office of General Counsel (OGC). It further states that VA Medical Center Fiscal Officers and other staff are without the authority to “write-off” third-party Accounts Receivable (AR) unless there is such OGC approval

3. RELATED DOCUMENTS. VA Handbook 4800.14.

4. FOLLOW-UP RESPONSIBILITY. The VHA Chief Financial Officer is responsible for follow up responsibility of this Handbook. Questions may be addressed to the VHA Accounting Policy mailbox in Outlook.

5. RESCISSION. None.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the December 31, 2011.

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WRITE-OFFS, DECREASES, AND TERMINATION OF MEDICAL CARE COLLECTIONS FUND ACCOUNTS THIRD-PARTY RECEIVABLE BALANCES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines the procedures involving decreases in and termination of Medical Care Collections Fund (MCCF) accounts receivable (AR) balances at all facilities. It outlines specific responsibilities for identified staff regarding their role in ensuring that all VHA financial transactions conform to accepted government accounting principles.

2. BACKGROUND

a. It is Department of Veterans Affairs (VA) policy that all VHA financial transactions must conform to accepted government accounting principles as stated in VA Directive 4800, VA Handbook 4800 series, and Office of Finance (OF) Bulletin 06GC1.04.

b. Inappropriate actions regarding the adjustment of third-party AR balances have been identified by multiple audits of MCCF receivable management activities. Facilities have been cited for writing off, adjusting, or decreasing balances without proper authority; inappropriately increasing the principal balance of receivables; and decreasing balances to zero to close out receivables without proper follow-up and documentation. These inappropriate actions are in direct conflict with existing statutes and policy guidance which further stipulates the requirement of prior approval by the VA Office of General Counsel (OGC). VA medical centers Fiscal Officers and other staff are without authority to “write-off” third-party AR without such OGC approval.

c. Organizational alignment and operational variation across VHA has further contributed to the potential for this financial management weakness. That notwithstanding, all staff are responsible for supporting the Chief Financial Officer (CFO) who is obligated under the CFO Act of 1990 to ensure that appropriate procedures are followed for the termination of collection activity and close-out of medical care debts.

d. Local management must create an environment of appropriate internal controls. Office of Management and Budget (OMB) Circular A-123 defines internal control as an integral component of organizational management that provides reasonable assurance that the following objectives are being achieved:

- (1) The effectiveness and efficiency of operations,
- (2) The reliability of financial reporting, and
- (3) Compliance with applicable laws and regulations.

3. SCOPE

Since it is VA policy that all financial transactions must conform to accepted government accounting principles, the mandates of this Handbook cover all VHA entities **NOTE:** *Further operational instructions for AR management can be found on the Chief Business Office website <http://vaww1.va.gov/cbo/>. For general third-party AR business rules, see Attachment A, for third-party AR processing examples, see Attachment B.*

4. RESPONSIBILITIES OF THE CHIEF FINANCIAL OFFICER (CFO)

a. The CFO is ultimately responsible for:

(1) All financial practices,

(2) The development and reporting of VHA financial management standards,

(3) Developing training materials for all levels of VHA finance staff, and

(4) Collaborating with the CBO in designing and implementing national monitoring and auditing procedures, appropriate internal control mechanisms and performance measures.

b. The CFO along with the CBO and Chief Compliance and Business Integrity Officer (CBIO) will develop a series of AR Performance Measures.

5. RESPONSIBILITIES OF THE CHIEF BUSINESS OFFICER (CBO)

The CBO is responsible for ensuring that activities associated with the generation and management of Revenue Cycle activities at medical centers or Consolidated Patient Accounting Centers (CPACs) comply with the standards and requirements articulated in the related financial policy. These activities include, but are not limited to:

a. Training of MCCF staff involved in billing and AR duties;

b. The development and distribution of appropriate training;

c. The development and distribution of appropriate revenue program standards;

d. Guidance in conformance with VA and VHA financial policy; and

e. Assisting the CFO in designing and implementing national monitoring and auditing procedures, appropriate internal control mechanisms, and performance measures.

f. The CBO along with the CBIO and CFO is responsible for developing a series of AR Performance Measures.

6. RESPONSIBILITIES OF THE CHIEF COMPLIANCE AND BUSINESS INTEGRITY OFFICER (CBIO)

a. The CBIO is responsible for:

(1) Training staff in business integrity and collaborating with the CBO and CFO in the maintenance of appropriate financial auditing practices.

(2) Monitoring and reporting the AR Performance Measures.

b. The CBIO along with the CBO and CFO is responsible for developing a series of AR Performance Measures.

7. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

The VISN Director is responsible for ensuring that facilities have appropriate internal controls in place and are in compliance with all financial transaction standards and guidance, regardless of the organizational design, location, or organizational element responsible for conducting AR activities.

8. RESPONSIBILITIES OF THE VISN FINANCIAL QUALITY ASSURANCE MANAGER (FQAM)

The VISN FQAM is responsible for performing the necessary audit activities associated with this Handbook and reporting the results of the monitoring to both the local and VISN CBI committees, the CFO, and the CBO.

9. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The facility Director is responsible for:

a. The establishment of applicable internal controls, and

b. Ensuring that financial staff members are aware of all applicable regulations and standards and for performing these actions irrespective of organizational alignment and/or operational responsibility assignment of AR activities.

10. RESPONSIBILITIES OF THE FACILITY REVENUE COORDINATOR (RC)

The facility RC is responsible for:

a. Collaborating with leadership and local Fiscal staff to ensure all AR staff performing financial transactions comply with applicable regulations, policies, and directives.

b. Internal monitoring activities accomplished as a routine component of business operations.

11. RESPONSIBILITIES OF THE FACILITY FISCAL OFFICER

The facility Fiscal Officer is responsible for ensuring that:

- a. All staff responsible for accomplishing financial transactions are adequately trained,
- b. Internal controls are being followed, and
- c. Financial activities conform to all established requirements.

12. REFERENCES

- a. [VA Handbook 4800.14](#), Medical Care Debts, establishes standardized Department-wide procedures for the collection of debts owed to VA as a result of the receipt of medical care or services from VA.
- b. [VA Handbook 4800.13](#), Statute of Limitations, explains the statute of limitations for various types of debt.
- c. [VA Handbook 4800.12](#) covers Referrals for Enforced Collections (Litigation).
- d. [VA Handbook 4800.6](#) addresses criteria required for Termination of Collection Action and Close out of Debts (this handbook applies to co-payment incurred by individuals for medical treatment and prescriptions).
- e. [VA Handbook 4800.5](#) covers policy for proper Suspension of Collection Activity.
- f. Public Law 101-576, the Chief Financial Officers Act of 1990.
- g. OF Bulletin 06GC1.04, Followup Procedures for Third Party Medical Care Debt, provides guidance in advance of an update to VA Handbook 4800.14.
- h. OF Bulletin 06GA1.04, Revision to Internal Control Guidelines, revises policy provided in MP-4, Part V, Chapter 1; Section A, paragraph 1A.10b, Control Through Assignment of Duties of Employees.
- i. MP-4, Part V, Chapter 1; Section A, paragraph 1A.10b, Control Through Assignment of Duties of Employees.

GENERAL MEDICAL CARE THIRD-PARTY ACCOUNTS RECEIVABLE (AR) BUSINESS RULES

Significant Applicable Business Rules that Only Apply to Third-party Receivables. The following are significant applicable business rules that only apply to third-party receivables:

1. If no payment is received after the fourth follow-up date, management must be made aware of the non-payment situation with the AR. **NOTE:** *Staff are reminded that all follow up activities must be documented within the appropriate Veterans Integrated Systems Technology Architecture (VistA) option.*

2. General Counsel and Regional Counsel are the only Department of Veterans Affairs (VA) entities allowed to determine if an AR is uncollectible. Until General Counsel or Regional Counsel makes that determination, the AR must reflect the actual value of the services rendered remaining uncollected.

3. If staff desire to utilize the services of an outside collection agency for collection of third-party AR the following guidelines must be followed:

a. The receivable is not to be sent to an outside source or collection before 90 days from the billing date.

b. When an outside source determines that no further collection is possible (e.g. the care was not pre-authorized or pre-certified, as required by the insurance company; medical treatment was not a medical necessity within the policy guidelines; was paid based upon usual and customary rates in the community for the care provided; etc.), the medical facility needs to follow the recommendation, and the balance of the claim is to be contractually adjusted down pursuant to VA Handbook 4800.14.

c. If a receivable has been referred to a contractor for collection and the MCCF Coordinator disagrees with the contractor's recommendation, the MCCF Coordinator needs to contact Regional Counsel for guidance, in accordance with VA Handbook 4800.14, subparagraph 4d, prior to referring the case.

d. Staff must not decrease the balance of third-party AR prior to, or subsequent to, referring the receivable to an outside source.

e. Third-party AR reduced to a \$0 balance in error must be re-established in AR with a comment in Third-party Joint Inquiry (TPJI) as to the reason of the re-establishment with necessary follow-up action or referral to Regional Counsel, as appropriate.

4. Generally, increasing the principal balance of AR beyond the original amount for which the AR was established is not permitted. A review of the explanation of benefits (EOB) needs to be conducted to determine if an amount received in excess of the billed charges is:

a. The usual and customary payment from the third-party payer in the same geographic area in which the medical care or services were provided and the third-party payor chooses not to pay the less billed charges, or

b. The result of a third-party payor re-bundling the coding or the originally submitted claim in accordance with their reimbursement and utilization review policies thereby resulting in a higher payment to VA.

5. Employees responsible for collecting revenues should not maintain or be in a position to adjust related accounting records.

6. The Fiscal Year-End Financial Reports and Statements Certification require certification that all ARs are correct as of September 30. To support this certification each facility must have documentation to support every receivable that is established and subsequent adjustments, deposits, and write-offs.

EXAMPLES OF APPROPRIATE AND INAPPROPRIATE THIRD PARTY ACCOUNTS RECEIVABLE (AR) ADJUSTMENTS

1. APPROPRIATE REASONS FOR DECREASING THIRD-PARTY BILLS. Appropriate reasons for decreasing third-party bills are:

- a. Partial payment received, and the payment received is the full amount expected from the insurance carrier. AR status will be Collected or Closed.
- b. Usual and customary payment received. AR Status will be Collected or Closed.
- c. Applied to deductible. AR Status will be Collected or Closed.
- d. Treatment does not meet medical necessity (this should be referred to Utilization Review (UR) prior to any decrease to file appeal)
- e. Insurance was not in effect for the time billed. AR Status will be Cancelled.
- f. Services are not covered under policy. AR Status will be Cancelled.
- g. Procedure is not a covered service. AR Status will be Cancelled.
- h. Procedure is not authorized (this should be referred to UR prior to any decrease to file appeal).
- i. Medicare Part A deductible was previously paid to another provider. Status will be Collected or Closed.

2. APPROPRIATE DECREASES. Examples of appropriate decreases are:

a. **Example 1.** A claim issued for \$100, Explanation of Benefits (EOB) received with a payment of \$80. After a review of the insurance coverage which determined that company pays at 80 percent of allowed charged, the \$80 payment will be posted and the claim contractually adjusted by \$20 and collected or closed. Comments must be documented that provide clear and unambiguous meaning of actions taken when entered into the Veterans Integrated Systems Technology Architecture (VistA)'s Third Party Joint Inquiry (TPJI).

Suggested Comment:

Paid at 80 percent of allowable.

b. **Example 2.** A claim is issued for \$100, EOB received with information that insurance will only pay 80 percent of the allowable charge. Allowable charge was \$50, payment received was 80 percent of \$50. The amount of \$40 will be posted to the bill and \$60 will be contractually adjusted with a collected/closed status. Comments must be documented that provide clear and unambiguous meaning of actions taken when entered into VistA's TPJI.

Suggested Comment:

Allowable charge \$50 – pd at 80 percent.

c. **Example 3.** A claim issued for \$150. EOB received stating that the insurance was not in effect for the treatment period. AR needs to be decreased with a status of cancelled. Comments need to be entered into TPJI and the Insurance and the Billing Office notified to follow-up and determine if the patient changed or cancelled coverage. Comments must be documented that provide clear and unambiguous meaning of actions taken when entered into VistA's TPJI:

Suggested Comment:

Insurance not in effect.

NOTE: All decreases must have a comment as to the reason for the decrease. Facilities should also refer to the Accounts Receivable Third-Party Guidebook for additional guidance.

3. INAPPROPRIATE DECREASE. An example of an inappropriate decrease is a claim generated to insurance carrier for outpatient care in the amount of \$150.00. Follow-up notices were sent with no response from the insurance carrier. TPJI does not indicate any other type of follow-up such as phone calls or referral to e-mail denials. Six months after the claim was generated the claim was written-off by the Fiscal Officer as inability to collect. The Fiscal Officer does not have authority to write-off any third-party claim. General Counsel and Regional Counsel are the only entities that have write-off authority. Any bill that was written off, or decreased to zero due to the inability to collect or was not cost effective to collect needs to be re-established and continued follow-up needs to be maintained.

4. INAPPROPRIATE INCREASE ADJUSTMENTS. Examples of inappropriate increase adjustments are:

a. **Example 1**

(1) The patient is covered by a Medigap policy and receives inpatient treatment. A claim is generated in the amount of \$68,000 and issued to Trailblazers. A Medicare-equivalent Remittance Advice (MRA) is received from Trailblazers indicating the patient's responsibility is \$952. The claim and MRA are forwarded to the Medigap carrier. A receivable is established in VistA for \$952. Payment is received from the carrier in the amount of \$31,000 (obviously an overpayment). The AR technician increases the principal balance of the receivable from \$952 to \$31,000 in order to retain the overpayment.

(2) No authority existed to increase the principal balance of the receivable. The AR technician should have applied the \$952 to the insurance bill, applied \$30,088 to suspense (36X3875), and initiated an action to refund the overpayment of \$30,088.

b. Example 2

(1) A claim is issued to an insurance carrier for \$1240. A third-party receivable is established in VistA (528704). The Fair Claims Practices regulations require the insurance carrier to pay interest on the reimbursable amount if the carrier doesn't adjudicate the claim within 45 days. The insurance carrier pays \$1,364. The AR technician increases the principal balance of the receivable from \$1,240 to \$1,364 in order to accommodate the interest payment.

(2) Interest payments need to be deposited to the General Fund Receipt account (36 1435). It is inappropriate to increase the principal balance of the debt to accommodate the interest payment.

c. Example 3

(1) A claim is issued to an insurance carrier for \$120 for treatment provided to Mr. Smith. VA receives payment in the amount of \$300. Upon receiving the payment, the AR technician contacts the insurance carrier for an explanation of their payment of the claim for Mr. Smith's treatment. The insurance carrier representative states "Yes, we overpaid VA on that claim by \$180, however, we don't need a refund, because we have offset your claim for treating Mr. Johnson on September 23rd." The AR technician increases the principal balance of Mr. Smith's claim by \$180, thereby retaining the overpayment, and decreases the balance of Mr. Johnson's claim by \$180, bringing the balance to zero.

(2) VA facilities may not adjust third-party claims in order to accommodate insurance carrier offset preferences. The correct action is to refund the overpayment of \$180 on Mr. Smith's claim.

5. APPROPRIATE INCREASE ADJUSTMENTS. Examples of appropriate increase adjustments are:

a. **Example 1.** A claim is issued to an insurance carrier for \$75 for treatment provided to Mr. Smith. VA receives a payment in the amount of \$100. Upon receiving the payment, the AR technician contacts the insurance carrier and inquires as to why payment is for a greater amount than the billed amount. The carrier's representative explains that the billed amount was less than their usual and customary payment, for this specific geographic area, for the Current Procedural Terminology (CPT) codes billed and their payment methodology does not allow for the payment of the lesser charges billed. The AR technician must increase the balance of the third-party claim up to the amount of the carrier's payment and apply the payment to the claim. The AR technician must document the contact with the carrier representative in TPJI and add a comment as to the payment methodology of the carrier.

NOTE: *Payment methodology information needs to be forwarded to insurance staff so they can add carrier or plan comments to the insurance file for this carrier or plan.*

b. **Example 2.** A claim is issued to an insurance carrier for \$250 for treatment provided to Mr. Smith. VA receives a payment in the amount of \$400. Upon receiving the payment, the AR technician contacts the insurance carrier and inquires as to why payment is for a greater amount than the billed amount. The carrier's representative explains that they re-bundled the coding of the original submitted claim in accordance with their reimbursement and utilization review policies and made payment reflective of their policies. The AR technician must increase the balance of the third-party claim up to the amount of the carrier's payment and apply the payment to the claim. The AR technician must document the contact with the carrier representative in TPJI and add a comment as to the payment methodology of the carrier.

NOTE: *Payment methodology information needs to be forwarded to insurance staff so they can add carrier or plan comments to the insurance file for this carrier or plan.*